

## INSTRUCTIONS

### APPLICATION FOR LICENSURE AS A NURSE PRACTITIONER

An applicant must submit the following to the Board of Nursing:

1. Application form completed in ink or typewritten, applicant's signature properly notarized, and
2. Fee of \$100.00 (for license and primary specialty, \$50.00 per additional specialty) in the form of U.S. check or money order in U.S. funds, made payable to the Treasurer of the State of Maine (may also pay by Visa or MasterCard) **APPLICATION FEE IS NOT REFUNDABLE**, and
3. Recent passport type photograph (not more than two years old), signed, dated, and enclosed with the application, and
4. Verification of basic nursing licensure from original state of licensure (**If you have a Maine RN license, active or inactive, you do not have to provide this information**), and
5. Verification of certifications as a nurse practitioner from your national certifying body(ies) (all specialties), and
6. A nurse practitioner must practice for a minimum of 24 months under the supervision of a licensed physician or nurse practitioner practicing in the same practice category as the applicant. Please submit a letter of supervision from a physician or nurse practitioner and an **Application for Approval of a Supervising Relationship with a Licensed Physician or Nurse Practitioner (registration fee is \$50.00)**. If you have completed this requirement out of state, please have the supervising practitioner submit a letter (on letterhead) indicating the time frame of supervision, hours per week, and a synopsis of the services you provided, and
7. Nursing transcript directly from your advanced practice nursing program, and
8. Declaration of Primary Residence form.

It is imperative that you provide your entire name (no initials), including any and all previously used names. If you do not have a middle, maiden, or previous names, than you must write NONE in the appropriate space.



**MAINE STATE BOARD OF NURSING**  
**158 State House Station • Augusta, Maine 04333-0158**  
**(207) 287-1133**

**APPLICATION FOR LICENSURE AS A NURSE PRACTITIONER**

**DO NOT WRITE IN THIS SPACE**

Application Received \_\_\_\_\_

Application Approved by Board of Nursing \_\_\_\_\_

Fee: Cash \_\_\_\_\_ Check \_\_\_\_\_ CC \_\_\_\_\_ MO \_\_\_\_\_

Chair \_\_\_\_\_

Receipt No. \_\_\_\_\_

License Date \_\_\_\_\_

Executive Director \_\_\_\_\_

APRN LICENSE NUMBER \_\_\_\_\_

Date \_\_\_\_\_

**SECTION I. PROFILE INFORMATION**

Print Legal Name

(first)

(middle)

(maiden)

(last)

List Any Other Names Used Previously

Residential Address \_\_\_\_\_

(street and number or route)

(city)

(state and zip code)

Mailing Address (if different from above) \_\_\_\_\_

(city)

(state and zip code)

If you reside out of the state of Maine, are you on a per diem assignment or is your intention to relocate to Maine? Please explain \_\_\_\_\_

Telephone number (H) \_\_\_\_\_ (W) \_\_\_\_\_ (CELL) \_\_\_\_\_

E-mail Address \_\_\_\_\_ Social Security Number \_\_\_\_\_

Birthplace \_\_\_\_\_ Date of Birth \_\_\_\_\_

(city/state)

(month/day/year)

## SECTION II. NURSING EDUCATION

**Basic** School of Nursing \_\_\_\_\_  
(name)

\_\_\_\_\_  
(street address) (city & state)

Date of Entrance \_\_\_\_\_ Date of Graduation \_\_\_\_\_ Length of Program \_\_\_\_\_

Diploma ☐ Associate ☐ Baccalaureate ☐ Masters ☐ Doctoral ☐ Certificate ☐

Accelerated Masters ☐ (Please provide information regarding previous degree) \_\_\_\_\_

**Advanced Practice** School of Nursing \_\_\_\_\_  
(name)

\_\_\_\_\_  
(street address) (city & state)

\_\_\_\_\_  
(Accrediting Agency e.g. NLNAC or CCNE) (dates of attendance)

Certificate ☐ Baccalaureate ☐ Masters ☐ Post Masters Certificate ☐ Doctorate ☐

List Nurse Practitioner Specialty(ies): Primary \_\_\_\_\_; Other Specialties:

## SECTION III. LICENSURE HISTORY

Do you now hold or have you ever held a license to practice nursing (registered or practical) in the State of Maine? Yes ☐ No ☐

If you have been issued a RN license, enter license number and expiration date.

\_\_\_\_\_  
Maine RN License No. Expiration Date

Original registration (**Basic Nursing Licensure**):

State/Country \_\_\_\_\_ Year \_\_\_\_\_ License No. \_\_\_\_\_ By Exam Yes ☐ No ☐

List **all** nursing licenses you have ever been issued LPN, RN, and NP. **Attach additional sheet if necessary.**

State or Country	License No	NP/RN/LPN	Date of Issue	Date of Expiration

#### SECTION IV. EMPLOYMENT INFORMATION

A. List employment in nursing for the past five years

Name of Agency	City and State	Dates of Employment	NP/RN/LPN

B. If you have not been employed in nursing in the past five years, please explain \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

C. Where in Maine do you plan to work? \_\_\_\_\_  
(name of facility/agency)

\_\_\_\_\_  
(street/route no./box no.) (town/city) (zip code)  
\_\_\_\_\_  
(contact name) (telephone number) (fax)

#### SECTION V. NURSE PRACTITIONER CERTIFICATION

A. Are you currently certified as a nurse practitioner by a national certifying body(ies)? Yes ☐ No ☐

If YES, indicate the certification specialties and certifying body(ies) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

If NO, indicate name of qualifying examination(s) and date(s) scheduled \_\_\_\_\_

\_\_\_\_\_ or  
indicate why you are not eligible to sit for nurse practitioner specialty qualifying  
examination(s) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## SECTION VI. PHARMACOLOGY AND PRESCRIPTIVE PRACTICE

A. Did you have a course in pharmacology in your nurse practitioner program? Yes ☐ No ☐

**IF YES,** how many credits and/or contact hours? \_\_\_\_\_  
(45 contact hours/3 credits required)

**IF NO,** but pharmacology was integrated, please have your program send a letter explaining how integration was accomplished and how much pharmacology was included. Please have your program include information regarding the following in its explanation:

1. Number of contact hours and/or credits (45 contact hours/3 credits required)
2. Applicable state and federal laws
3. Prescriptive writing
4. Drug selection, dosage, and route
5. Information resources
6. Clinical application of pharmacology related to specific scope of practice

**IF NO,** but you have obtained contact hours or credits in pharmacology in a formal academic setting or non-credit continuing education offerings, please provide certificates and documents that verify the offering covered in the information numbers 1-6 or have your program send official transcripts **directly** to the Board.

B. Have you prescribed in the last two years? Yes ☐ No ☐ New NP Graduate \_\_\_\_\_

**IF YES,** please provide documentation from your current/former employer that you prescribed medications in the last two years.

**IF NO,** please provide the Board with documentation of 15 contact hours of recent (within the last two years) continuing education in pharmacology.

Have you prescribed in the last five years? Yes ☐ No ☐ N/A ☐

**IF NO,** please provide the Board with documentation of 45 contact hours (3 credits) of recent (within the last two years) continuing education in pharmacology.

## SECTION VII. DISCIPLINARY INFORMATION

- A. Has any Board of Nursing ever fined, warned, censured, or reprimanded you? Yes ☐ No ☐
- B. Have you ever had a nursing license placed on probation, denied, suspended or revoked in any state? Yes ☐ No ☐
- C. Is there any complaint pending against your license in any state or jurisdiction? Yes ☐ No ☐
- D. Have you ever been disciplined for problems resulting from a physical illness or condition? Yes ☐ No ☐
- E. Have you ever been disciplined for problems resulting from mental illness? Yes ☐ No ☐
- F. Have you ever been disciplined for problems resulting from chemical dependency? Yes ☐ No ☐
- G. Have you ever been convicted of a crime other than minor traffic violations? Yes ☐ No ☐

**If you answered "YES" to any of the above questions, indicate all state(s) or jurisdiction(s) involved and attach an explanation.**

**THIS FORM MUST BE NOTARIZED**

**TAPE TOP ONLY**  
one recent photograph

Sign back of photo and  
indicate year taken

Photo must be:

Full Face View

Passport Type

Clear and recognizable  
likeness

I, the undersigned, being duly sworn, say that I am the person referred to in this application for licensure in the State of Maine, that the statements contained herein and on all attachments are true and correct in every respect, that I have complied with all requirements of the law, and that I have read and understood this affidavit.

Signature of Applicant \_\_\_\_\_

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

(SEAL)

Notary Public \_\_\_\_\_

My commission expires \_\_\_\_\_ in and for the State of \_\_\_\_\_

MAINE STATE BOARD OF NURSING

158 State House Station

Augusta, ME 04333-0158

VERIFICATION OF REGISTERED NURSE LICENSURE

TO \_\_\_\_\_ Board of Nursing

Name of Applicant \_\_\_\_\_  
First Middle Maiden Last

Present Address \_\_\_\_\_

License Number \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security Number \_\_\_\_\_

Information below to be completed by Board of Nursing in your State of original licensure

High School Diploma: Yes \_\_\_\_\_ No \_\_\_\_\_ Equivalency \_\_\_\_\_

Nursing Program: Name \_\_\_\_\_

Location \_\_\_\_\_

State Accredited: Yes \_\_\_\_\_ No \_\_\_\_\_ Length of Program \_\_\_\_\_

Date of entrance \_\_\_\_\_ Date of completion \_\_\_\_\_

Associate degree \_\_\_\_\_ Baccalaureate degree \_\_\_\_\_ Diploma \_\_\_\_\_

License number \_\_\_\_\_ Date issued \_\_\_\_\_ Date current license expires \_\_\_\_\_

Issued on the basis of examination \_\_\_\_\_ ; endorsement \_\_\_\_\_ ; waiver \_\_\_\_\_

Has license ever been suspended, revoked, probated, reprimanded or limited/restricted? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please attach explanation.

\*Results of State Board Test Pool Examination/NCLEX

Series Number \_\_\_\_\_

Scores:

\*Please indicate if examination was taken more than one time.

Medical Nursing \_\_\_\_\_

\*\*If applicant did not write SBTPE/NCLEX, specify type of test and list subjects and grades on back.

Psychiatric Nursing \_\_\_\_\_

Obstetric Nursing \_\_\_\_\_

NAME \_\_\_\_\_

Surgical Nursing \_\_\_\_\_

TITLE \_\_\_\_\_

Nursing of Children \_\_\_\_\_

STATE \_\_\_\_\_

Comprehensive NCLEX \_\_\_\_\_

DATE \_\_\_\_\_

Canadian Examinations:

CNATS \_\_\_\_\_ Provincial \_\_\_\_\_

(SEAL)

Taken in English \_\_\_\_\_ French \_\_\_\_\_

# LICENSE VERIFICATION REQUEST FORM

**\*\*\* NEW \*\*\*** Want to process your verification faster? Try our new secure Online Verification to process your verification immediately. Go to <https://www.nursys.com>

Please use blue or black ink.

See reverse side for form eligibility and instructions. ➡

## PERSONAL INFORMATION

Social Security Number:		Date of Birth: (mm/dd/yyyy)	
First Name:	Middle Name:	Last Name:	
Maiden Name:	Date of Original License (mm/yyyy)		
Street Address:			
City:	State:	Zip/Postal Code:	
Country:	Home Phone:	Work Phone:	

## ENDORSEMENT INFORMATION List the license types that you need verified

License Type (check one)	Total Verification Fee
LPN: <input type="checkbox"/>	\$30.00
RN: <input type="checkbox"/>	\$30.00
Both LPN & RN: <input type="checkbox"/>	\$60.00

Fees are not refundable

The only acceptable forms of payment are  
**CERTIFIED CHECK, CASHIER'S CHECK,**  
or **MONEY ORDER.**

Made payable to: NCSBN  
DO NOT SEND cash, personal checks, business checks, or travelers checks.

## LICENSE INFORMATION List all licenses that you have ever held

Jurisdiction/State	RN License Number	PN License Number
Original _____	_____	_____
Additional _____	_____	_____
Additional _____	_____	_____
Additional _____	_____	_____

States applying to: \_\_\_\_\_

I, the above named individual, hereby apply for verification to the National Council of State Boards of Nursing to permit NCSBN and/or its Member Boards to verify my licensure, educational, disciplinary, and related information in Nursys® for the purposes of supporting my request for endorsement verification in the jurisdiction(s) listed above and any other states in which I have ever been licensed. I also confirm that the information I have submitted is true.

My application fee of \$ \_\_\_\_\_ in guaranteed funds is attached.

### Mail this form to:

National Council of State Boards of Nursing, Inc.  
35331 Eagle Way  
Chicago, IL 60678-1353  
DO NOT SEND THIS FORM TO YOUR BOARD OF NURSING

Signature \_\_\_\_\_

Date \_\_\_\_\_

## FORM INSTRUCTIONS

1. Only boards of nursing within the United States have access to Nursys®. If you need verification of a license for a foreign country or to an agency other than a state board of nursing, please contact your state board of nursing.
2. You **MUST CONTACT** the state where you are seeking licensure to determine which state(s) they require verification from, as boards of nursing have different requirements.

If you do not need verification of a license from one of the states listed below, DO NOT complete this form. Instead, follow the verification instructions of the state where you are seeking licensure. Complete this form **ONLY** if the state where you are seeking licensure requires verification from one of the states listed below.

Alaska (AK)	Kentucky (KY)	New Hampshire (NH)	Tennessee (TN)
Arizona (AZ)	Maine (ME)	New Jersey (NJ)	Texas (TX)
Arkansas (AR)	Maryland (MD)	New Mexico (NM)	Utah (UT)
Colorado (CO)	Massachusetts (MA)	North Carolina (NC)	Vermont (VT)
Delaware (DE)	Minnesota (MN)	North Dakota (ND)	Virginia (VA)
Florida (FL)	Mississippi (MS)	Ohio (OH)	West Virginia - PN (WV)
Idaho (ID)	Missouri (MO)	Oregon (OR)	Wisconsin (WI)
Indiana (IN)	Montana (MT)	South Carolina (SC)	
Iowa (IA)	Nebraska (NE)	South Dakota (SD)	

3. Please complete all sections of this form. Forms with missing information or incorrect payments will be returned. **SEND ONLY THIS FORM AND PAYMENT. ALL OTHER FORMS ARE UNACCEPTABLE.**
4. **PAYMENT:** To verify RN licenses, the total fee is \$30, regardless of how many states you are licensed in or how many states you are applying to. To verify LPN licenses, the total fee is \$30, regardless of how many states you are licensed in or how many states you are applying to. To verify both RN and LPN licenses, the total fee is \$60, regardless of how many states you are licensed in or how many states you are applying to.  
  
All payments must be in guaranteed funds. **The only acceptable forms of payment are: certified checks, cashiers checks, or money orders – made payable to the NCSBN.** DO NOT SEND cash, personal checks, business checks, credit cards, or traveler's checks. Fees are non-refundable.
5. Please complete this form in blue or black ink. Print or type clearly. Illegible forms will be returned.
6. Verifications are entered into Nursys® in the order in which they are received at NCSBN. **The verification report will remain in Nursys® for 90 days, after which it expires.** When the Board of Nursing receives your Endorsement Application, the board will access Nursys® to verify any licenses held in the states listed in number 2 above. No paper reports are sent from NCSBN.
7. **EXPIRED REPORTS:** If your verification has expired, you must pay an additional \$30 and submit a new verification request form to NCSBN.
8. Nursys® information is updated from the participating nursing boards listed in number 2 above. A nurse who recently received a license may have to wait until the next update before the information is available in Nursys® for license verification.
9. If you have questions regarding this form, please contact the Nursys® License Verification Department at (312) 525-3780 or toll free (866) 819-1700.

**\*\*\* NEW \*\*\*** Want to process your verification faster? Try our new secure Online Verification to process your verification immediately. Go to <https://www.nursys.com>



JOHN ELIAS BALDACCI  
GOVERNOR

STATE OF MAINE  
BOARD OF NURSING  
158 STATE HOUSE STATION  
AUGUSTA, MAINE  
04333-0158

**DECLARATION OF PRIMARY STATE OF RESIDENCE**

MYRA A. BROADWAY, J.D., M.S., R.N.  
EXECUTIVE DIRECTOR

Name: \_\_\_\_\_ Social Security Number \_\_\_\_\_

Permanent/Residential Address:

\_\_\_\_\_  
(Apartment #, RR#, Street)

\_\_\_\_\_  
(City, State, and Zip Code)

Mailing address: (If same as above check here \_\_\_\_\_)

\_\_\_\_\_  
(PO Box, Apartment #, RR#, Street)

\_\_\_\_\_  
(City, State, and Zip Code)

Telephone Number \_\_\_\_\_ Email address: \_\_\_\_\_

( ) Yes ( ) No Are you currently employed in the U.S. Military (Active Duty) or  
the U.S. Federal Government?

In accordance with Chapter 11 Regulations Relating to the Nurse Licensure Compact  
Part II, 2.a. of the Nurse Licensure Compact Rules and Regulations, I declare that the  
State of \_\_\_\_\_ is my primary state of residence and is my legal state of residence.

I affirm that the contents of this document are true and correct to the best of my  
knowledge and belief. Providing false or misleading information may result in  
disciplinary action by the Board.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Print Name)



PRINTED ON RECYCLED PAPER